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Editor—C. W. MacCHARLES Medical Historian—ROSS MITCHELL

Medical Services for Citizens "on Relief"

MEMBERS of the profession generally are aware of the stage that has been reached in the negotiations with the Governments with regard to medical care to citizens "on relief."

The Municipal Councils of Greater Winnipeg have been advised that on and after July 1st, 1933, members of the medical profession will not contribute free medical services to citizens in receipt of relief funds — with certain specified exceptions. The general hospitals have been further advised that the members of the Honorary Attending Staffs of both out-patient and in-patient departments, on and after July 1st, 1933, will not provide medical services to patients "on relief"—again with certain specified exceptions.

In reply to a request from the Municipal Council of Winnipeg, the outline of a scheme for providing medical services to relief cases was submitted on February 25th, 1933. It might be well to recall the scheme which was suggested.

1. A central office shall be maintained for the registration, by the Relief Commission, of all persons on relief.
2. A person on relief requiring medical services shall call his family physician.
3. The physician shall notify the central registration office of such attendance within twenty-four (24) hours of having rendered same.
4. Such attendance shall be paid for by the City Relief Commission on a scale of fees which shall be fifty (50) per cent. of the regular schedule as set out by the Winnipeg Medical Society and the Manitoba Medical Association.
5. No further attendance shall be given without the authority of the central registration office, on which shall rest the responsibility of notifying the physician regarding further attendance.
6. A form shall be provided for the physician's report, which, along with other data, shall call for an estimate of the attention likely to be required.
7. Details of all medical attention shall be recorded on the patient's file at the central office.
8. Persons on relief who are ambulatory cases shall make application at the central office and receive a card to be presented to their own physician at his office, or (having no family physician) to a physician designated on his card.

9. A roster of physicians, showing branch of medicine engaged in, shall be kept at the central office and followed in rotation for such cases as have no family physician.
10. Medical treatment shall include medical, surgical and obstetrical treatment.
11. Arrangements for confinement cases shall, where possible, be made in advance at the central office.
12. The medical profession shall, by means of a committee or otherwise, give every assistance to the Relief Commission in preventing or arresting abuses, and in promoting the smooth working of this agreement.
13. Physicians' accounts shall be rendered monthly.

If this plan were discussed by the municipal authorities with the profession, no doubt details could be worked out. If the municipal authorities do not see fit to discuss the plan, they may, of course, allow the whole matter to drift and make no provision for medical services for citizens on relief. If they do so, it will be their responsibility. It is possible, of course, that the municipal authorities may decide to appoint a few full-time physicians to care for relief cases, and make no attempt to adopt the comprehensive scheme suggested by the profession. Any member of the profession who is approached with a proposition such as this will naturally refer the matter to the Central Committee.

If it should so happen that a member of the profession were considering accepting such an appointment without first discussing it with the representatives of the general body of the profession, he would be considering the matter purely from the point of view of what was to his own advantage, and therefore would naturally weigh carefully the balance between any temporary financial advantage that might come to him as a result of accepting the appointment, as against any unfortunate repercussion in his relations with his professional colleagues in later years.

No matter what happens immediately after July 1st, it is evident that ultimately some such scheme as that outlined by the profession will be adopted, for it is the only scheme that provides a comprehensive medical service for citizens who are on relief.

—C. W. MacC.

On the Organization of the Medical Profession

By F. D. McKENTY

"Organization is a harmonious adjustment of specialized parts for the accomplishment of some common purpose or purposes."—*Prof. Haney.*

THE medical profession of this province fails to meet this simple essential. There are a number of comparatively small bodies within the field of medicine which are effectively organized for a particular purpose, such as the teaching and hospital staffs, etc. There are larger bodies of more primitive structure (*and less definite aims*), such as the Manitoba Medical Association and the Winnipeg Medical Society, and between some of these bodies there exist vague relations. But if any social organization outside of medicine, for instance a government, finds it necessary to obtain a verdict upon a given question, or to rely upon efficient and concerted action by the

whole profession, the present form of medical association has proven cumbersome and inadequate. Instances of action, at times vague and lethargic, at times hasty and disproportionate by the different medical bodies can be recalled. Such a condition greatly reduces the capacity of the profession to act as a specialized social unit, and to fulfil its responsibilities for organized social service. Such responsibilities include the solution of various insistent problems which directly concern the profession, such as co-ordinating efficiently the various specialized branches of medical service, control of free clinic work, and the organization of state and industrial medicine, and health insurance. In order to do this efficiently, there is needed some single responsible body which can focus the intellectual resources of the profession on the task, and supervise and correlate the activities of the different branches.

It is clear that the concession of the right of supervision is the main difficulty, a problem so great that some may regard it as insoluble. But it is also clear that efficient organization depends on its solution. It is useless to wish for an end unless we are willing to follow the road to it. It is not to be expected that the legally established medical bodies with their responsibilities to the public and their independent status, can accept a fully subordinated relationship to any central voluntary body. Some feasible compromise would have to be found. Nevertheless, it must be conceded that the activities of these bodies are a serious and legitimate concern of the general profession, in that they affect its relationship to the public and endanger the professional qualifications and economic welfare of its members. Unrestrained enthusiasm in special fields has already reacted in injury to the public and the profession. These facts are not only obvious, but even admitted. Witness to this is the multiplication of free clinics beyond all need with their resultant evils, organized competition in free medical service to all and sundry, and increase in the tendency to pauperization in the recipients. Through the intenvention of an administering organization, the personal responsibility of those giving such free work is lessened, and the moral value to the giver is largely nulified. Those members of the profession who do not give their work to free clinics suffer in other ways, through loss of experience by the diversion and concentration of pauper patients at free clinics, through loss of at least a part of their clientele who might, but for the competition of free clinics, avoid pauperization by making some return within their means, and indirectly through the taxing of that 80% of the population who subsist without margin, with the cost of maintaining elaborate and expensive medical service for the socially insolvent. The subsidizing of the teaching industry has magnified this field from secondary into primary importance, and obscured the main aim of medicine which is the care of the health of the community here and now. The evils of excessive competition in general are admitted—lowering of quality, high pressure salesmanship, etc. In medical practice, the patient whose well-being is at stake is little able to judge the quality of the service. His best guarantee is the character of the practitioner. If this inestimable factor is jeopardized, the public standing of the profession is correspondingly injured. The involved relationship between teaching and hospital administrations and the exploitation of the free or pay clinics need clarifying. It is significant that in this country there are practically no free clinics outside teaching centres.

In these developments, the general profession, whose interests are so much at stake, has had small voice, and no effective machinery has existed by which it could be expressed. Everything indicates that, perhaps because of these same developments, the profession is on the eve of great changes in its relationship to the public. Firm ground for the necessary negotiations

of these changes must be sought in a reconsideration of the basic functions of medicine as a liberal profession and a re-valuation of its present diverse activities in relation to its main aim. For such purpose, some permanently functioning medical body is needed, which will represent effectively its various components. Within this body, the aims of the various branches can be expressed and co-ordinated into some common policy in which specialized aims may be proportioned to the whole. A rigid or complex organization is neither practical nor desirable under changing conditions.

A dispassionate consideration of the situation will remind us that the authority of a voluntary representative constitution should be sufficient for our purpose. The function of such a body should be mainly, advisory, and it should be the channel through which the relations of the profession with the public and the special organizations with each other would be conducted. There is no need to form any new medical organization. It is suggested that such an Advisory Council might be very simply formed by merely expanding the present executive of the Provincial Medical Association to include as ex-officio members the heads of the medical faculty, the College of Physicians and Surgeons, and possible the Deputy Minister of Health, all members to have authority to act as spokesmen for their organization. To involve the College of Physicians and Surgeons in a centralizing movement further than in an advisory capacity would be wrong, as the College is not a real medical body at all within the present use of that term.

Skepticism may be felt as to the likelihood of finding men of the right calibre who would be willing to undertake the duties involved, but the claim upon the service of such men will have strength in proportion as it helps to implement the broad aim of enlightened public service, and the profession may be trusted to reach the standard which has justified public trust in the past.

As the only recognized body of experts in the field, the medical profession expects to have an important voice in the adjustments of medical service which appear imminent. The public on the other hand is justified in looking to the profession for the best possible assistance. Failure to meet this test with the spirit and resource of a liberal profession will react in lowered prestige and injury to the ultimate interest of its members.

NOTE: This is the first of a short series of articles on the organization of the medical profession. They are being published with the object of stimulating thought and discussion about a problem which is of very great importance to the medical profession at the present time.—EDITOR.

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(1) WIENER KLINISCHE WOCHENSCHRIFT,
Priv. Doz. Oskar Stracker,
"Zehendeformitäten" (Deformities of the toes).

Dr. Stracker discusses the different forms of toe-deformities, their etiology and their treatment. In cases of chronic inflammation of the metatarsophalangeal joint of the great toe, the author calls attention to the possibility of this condition being easily mistaken for arthritis. For its treatment he recommends massage diathermy and internally urecidin. In acute onset, local antiphlogistic treatment with Antiphlogistine proved of great value. To lessen the pain when walking, it is recommended that two strips of wood, placed at right angles, be attached to the sole of the shoe in the area of the ball.

Western Canada Medical History

by Ross Mitchell

The Rebellion of 1885

MEDICAL ARRANGEMENTS OF THE CAMPAIGN

THE disturbances in the Red River Settlement in 1869 and 1870 in which Louis Riel played a leading part resulted in little bloodshed, and, but for the unpardonable shooting of Scott, Riel's course in the period of transition from the rule of the Hudson's Bay Company to that of the Canadian Government, would have found many sympathizers. He was included in the general amnesty urged upon the Canadian Government by Archbishop Taché, was returned in 1873 a Member of Parliament for Provencher by acclamation and again returned in the election of 1874. However, he was not allowed to take his seat, and in 1875 he was sentenced to five years' banishment and forfeiture of political rights. Many of the Metis who had been his followers moved from Manitoba and formed a settlement on the south Saskatchewan under the leadership of Gabriel Dumont, a well-known buffalo hunter.

The building of the Canadian Pacific Railway in the early 80's caused settlers from eastern Canada and England to pour into the North-West Territories, and once again the conditions prevailing in 1869 obtained. Possibly Ottawa did not pay sufficient heed to representations from the Territories and no doubt there were some grievances among the half-breeds and Indians, though certainly none so great as to warrant armed rebellion. A deputation of four, among them Dumont, in the summer of 1884 waited on Riel who was teaching school in Montana and urged him to return and act as their leader, which he did. Numerous meetings were held throughout the North West and Riel's powers of oratory made him the undisputed leader of the Metis.

The first overt act was committed when Riel requested the French half-breeds to bring their arms with them to a meeting to be held on March 3rd, 1885. On March 18th stores at St. Laurent were raided and prisoners taken, and on March 26th the first clash of armed forces occurred at Duck Lake between the rebels and the force under Major Crozier of the N.W.M.P. when nine Prince Albert volunteers and three policemen were killed and twenty-five wounded. Word was flashed to Ottawa where the importance of speedily quelling an insurrection which might involve a general Indian uprising was at once recognized. Major-General Fred Middleton, then commanding Canadian Militia, was appointed leader of the expedition which was made up of forces from all Canada.

The Canadian force advanced in three columns, one under Gen. Middleton which fought engagements at Fish Creek, April 24th, and at Batoche, May 9th to 12th; one under Col. Otter which relieved Battleford and engaged Poundmaker's Indians at Cut Knife Hill, May 2nd; and another under Major-General Strange which marched from Calgary to Fort Pitt against Big Bear's Indians who committed the terrible massacre at Frog Lake on April 2nd. Strange's column fought them at the Red Deer River on May 28th. Our readers will readily appreciate the difficulties encountered by these small detachments passing through a sparsely settled country of magnificent distances and at an inclement season against a crafty and very elusive enemy.

To put down within two months an uprising of frightful possibilities was a notable feat of organization. The capture of Batoche, Riel's headquarters, was the turning point of the campaign. Riel escaped, but gave himself up two days later, was conveyed to Regina where he was tried, and on 16th November was executed.

According to Major Boulton, leader of Boulton's Scouts, in his *Reminiscences of the North-West Rebellions,* the arrangements of the medical staff were excellent. The Surgeon-General at Ottawa was Dr. Darby Bergin, but most of the credit for the organization of this branch was due to the Deputy Surgeon-General Dr. (afterwards Sir) Thomas A. Roddick, of Montreal. With Manitoba units in the field were Dr. J. W. Whiteford, 90th Winnipeg Rifles, one of the founders of Manitoba Medical College, and Dr. J. P. Pennefather, 92nd Winnipeg Light Infantry, who embodied his experiences in *Thirteen Years on the Prairies*; Dr. M. M. Seymour, later Deputy Minister of Health for Saskatchewan, and Dr. G. S. Keele, who practised for many years at Portage la Prairie, were the surgeons with the 91st Winnipeg Battalion. The surgeon with Boulton's Scouts was Dr. P. N. Rolston, former surgeon with the Royal Navy. A hospital with John H. C. Willoughby as surgeon was established at Saskatoon, where the wounded from Fish Creek and Batoche were conveyed and a staff of nurses appointed under the direction of Nurse Miller of the Winnipeg General Hospital. The hospital at Battleford was established for Colonel Otter's column with Dr. F. W. Strange as surgeon. Afterwards a general hospital was established at Moose Jaw staffed with such well known surgeons as T. G. Roddick, C. M. Douglass, James Bell, E. A. Graveley, Robert Tracy, F. H. Powell, W. W. Doherty, Robert Reddick, George T. Orton, M.P., Alex. Kennedy, E. E. King, J. S. Freebourn, H. A. Wright. The Winnipeg Hospital staff consisted of Surgeon Major James Kerr, first dean of the Manitoba Medical College, Assistant Surgeons F. H. Mewburn, late Professor of Surgery, University of Alberta, and Edward Benson. A staff of dressers from the various medical colleges was also sent forward to assist the regimental surgeons. Several of these students later became leaders in Canadian medicine.

In his despatch to the government at Ottawa Major-General Sir Fred Middleton mentioned Dr. Roddick of Montreal, Deputy Surgeon General; Dr. Orton of Winnipeg, Brigade Surgeon; Dr. Graveley of Cornwall, Brigade Surgeon on Dr. Orton's departure; Dr. Bell of Montreal, and Nurse Miller "whose services as Head Nurse to the wounded were invaluable and unremitting." Surgeon Pennefather was mentioned in the despatch from Major-General Strange May 28th, 1885, for his devotion to duty in the action at the forks of the Red Deer and Little Red Deer rivers.

Major Boulton gives the following account of the close of the fighting at Fish Creek on April 24th: "Towards four o'clock in the afternoon, the General ordered the firing to cease, and the small body of the enemy still remaining were only too well satisfied to abandon the conflict. Comparative quietness now reigned, and an opportunity was given the doctors to attend to the wounded, among whom they had already been busy. Dr. Orton, M.P., Brigade Surgeon; Dr. Rolston, of my troop; Dr. Grant, of the artillery; Dr. Whiteford, of the 90th, were all doing their best to relieve the distressed and suffering men. They were moderately well-prepared with instruments and bandages, although, not being accustomed to war or expecting such calls upon their resources, they were somewhat deficient. A corral, about six hundred yards from the ravine, had been formed of the transport of Mr. Bedson, assisted by Mr. Secretan, and in the centre of this an hospital was

improvised. The casualty list was anxiously conned, and was found to amount to eight killed and forty-four wounded.'' Among the killed was Alexander M. Fergusson, a medical student in Manitoba Medical College, and a son of Dr. R. B. Fergusson of Winnipeg. Col. I. R. Snider, who was in this fight as a member of the 90th Battalion, has recently told how the wounded were despatched to Saskatoon in improvised ambulances made by stretching fresh killed cow-hides across wagon boxes where they were lashed with raw-hide thongs.

Canada was only a young country when this campaign was carried on, but it must be admitted that taking everything into consideration, the casualties were few and the medical arrangements adequate.

* * * *

Twenty Years Ago—April 15, 1913

Col. John Pyne Pennefather, M.D., whose name had been linked with the history of Winnipeg for the past 30 years, passed away at the home of his daughter, Mrs. M. J. Hemmeon, Kennedy street; he was 80 years of age and died on the exact anniversary of his arrival in Winnipeg in April, 1880.

* * * *

Forty-five Years Ago—April 21, 1888

There was shortly to be a general scattering of newly made M.D's of Winnipeg to outlying towns; Dr. Latimer was to settle down and practice at Carman or Emerson; Dr. Large at Virden; Dr. McIntyre at Pilot Mound; Dr. Sibbit at Neepawa, and Dr. Gemmel at Manitou.

* * * *

Fifty Years Ago—May 4, 1883

The town of Minnedosa was to have another M.D., in the person of Dr. Roche, son of W. E. Roche, pioneer citizen.

* * * *

Sixty Years Ago—May 5, 1873

The Winnipeg General Hospital was moved to its new location on the bank of the Red river, about midway between Post Office (Lombard) street and the junction of the Assiniboine. The new building was isolated, spacious, tidy and in a healthy location.

* * * *

Thirty-five Years Ago—May 9, 1898

The Winnipeg General Hospital was shortly to be increased in size by the addition of a large wing, the Victoria jubilee addition, with accommodation for about 75 patients; building committee, G. J. Maulson, D. E. Sprague, Stephen Nairn and Wm. Hespeler.

Specific Therapy in Erysipelas

Symmers, comparing 15,277 cases of erysipelas treated without antitoxin over a period of 23 years with 705 cases treated with antitoxin, found an apparent reduction in mortality in serum treated cases of 44.5%. Symmers remarks (J.A.M.A., August 25, 1928) "The antitoxin treatment of erysipelas marks an advance, the results of which are commensurate with those obtained in the treatment of diphtheria."

★

Parke-Davis Erysipelas Streptococcus Antitoxin is obtained from the blood of horses immunized against the streptococcus from highly virulent cultures of Streptococcus hemolyticus isolated from erysipelas. This antitoxin is refined and concentrated, the antitoxic properties being retained in very small bulk; the product is free from most of the inactive serum constituents.

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The New Canadian Formulary

By M. J. OMEROD, M.D.

Assistant Professor of Physiology and Pharmacology
University of Manitoba

IN 1925, when revision of the 1914 British Pharmacopœia was first suggested, a joint committee of the Canadian Medical and Canadian Pharmaceutical Associations was appointed to represent Canada in the revision. This Committee on Pharmaceutical Standards, as it was called, was composed of men from all parts of Canada, and the members were in constant touch with each other. As the work progressed, it became very evident that some drugs which were in common use in this country would be deleted from the new B.P., and that standards of potency or purity in some cases would be lower in the B.P. than we were accustomed to in Canada. The solution appeared to be the publishing of a Canadian Addendum to the Pharmacopœia. At this time, the Pharmaceutical Association asked the Committee to undertake revision of the old Canadian Formulary. This publication had hitherto been almost exclusively a pharmaceutical one: many of the formulæ contained in it were so complex that the medical men suspected their real value as compared with their cost, and the book never became really popular among the physicians. Again, the very complexity of the formulæ prevented the practising pharmacists from manufacturing them in their own stores. This seemed an opportunity to scrutinize the contents of the book from the standpoint of both physician and pharmacist, and the Committee also saw in this an opportunity of publishing their Addendum at the same time.

First steps in this revision were detailed criticism of, and voting upon the old preparations. Many of these were removed at first vote, and others at subsequent votes. Criticism of others led to the establishing of a testing laboratory where the various modifications came under close scrutiny and trial, and the most promising formula evolved was again submitted to the Committee for approval. New formulæ were requested from both sides of the Committee, and these in turn were submitted to test and vote. The first section of the new Formulary contains the result of this work, and the preparations listed therein have been satisfactory to both the doctor and the druggist. In all cases, simplicity was a first consideration, and was not sacrificed to the demand for palatability or appearance. Combinations were made from a scientific aspect, and useless or supernumary drugs were deleted. We believe this section of the Formulary may be used *in toto* by hospitals with advantage, and also that medical men will find in these pages simple, palatable and efficient preparations which can readily be prepared at any pharmacy.

The Addendum section contains various drugs deleted from the 1932 B.P. as well as other drugs having a common use in Canada which were not included in the B.P. In addition, various elixirs and other galenical preparations for which a steady demand exists, are included, after criticism and revision of their contents, in many cases. Thus, the much-favoured and needlessly complex and expensive Elixir Lactated Pepsin has been removed, and the Elix. Aromat. Rubrum replaces it. It was found that such samples of the old Elix. Lactopep. as really had enzymes placed in them, lost their activity very shortly: either the pepsin digested the pancreatin, or *vice versa*. Again, the Formulary analogue of the patent Listerine, known formerly as

Liquor Antisepticus, has been renamed "Aromatic Mouthwash," to more accurately show its status in scientific medicine. Morphine Sulphate is probably the most commonly used salt of morphine, yet it has never been in the 1914 or 1932 B.P.: it has been given space in the Formulary. Syrup of Codeine Phosphate does not appear in the B.P. now: an improved form of it is in the Formulary. Syrup Sassafras Co. is a useful addition which will find ready use in flavouring some of the saline mixtures. Biological products such as sera and vaccines are under control of the Food and Drugs Act in Canada, hence are listed in the Addendum with this legal warning.

The third section of the Formulary contains preparations which are known by common names, such as Javelle Water, Fuller's Lotion, Eusol, etc. In many cases, when the Committee looked for the formula of such a preparation they were rather dismayed to find several formulæ in circulation. The one selected was that one which, from the literature, was the original formula, or else the most commonly used variant was chosen for the Formulary. In some cases, therefore, the formula given will not coincide exactly with the one in use by a person or institution. This section is really for the pharmacist, enabling him to prepare material with the least waste of time in looking for the formula.

One distinct departure from the old Formulary is the absence of heroin from elixirs, etc. This has been done intentionally: the drug may be substituted almost entirely in cough mixtures, etc., by codeine, or in some cases, paregoric. In view of the attitude of the United States, which has forbidden the sale, manufacture or importation of this drug in the U.S.A., once the available stock in the country is used, and also considering the findings of the League of Nations committee on this drug, it was felt that its use in any Formulary preparations would certainly be unnecessary and in fact, unscientific.

Because of this deletion, and because also of the standards laid down by the new Formulary, it has received the formal sanction of the Dominion Department of Health: it is to be considered the standard for unofficial preparations in this country. This has been very gratifying to the Canadian Pharmaceutical Manufacturers' Association also, since unfair competition of cheaply-made preparations is thus eliminated. No matter what firm manufactures Elixir. Triple Brom., for instance, it must satisfy the requirements of the Formulary. This will not result in increased local prices, but will have the opposite effect, since standard methods will be followed by all, and useless high-pressure advertising will be discarded.

The Formulary, as it now stands, has the approval of all the interested organizations. It remains to be adopted and popularized by the members of the medical profession. We believe this will occur in short order. Where there are criticisms of its form or contents, the members of the Committee would appreciate receiving suggestions for improvement of the book. We hope that the book will meet with widespread use, and believe it is in the best interests of all concerned that this should be the case. One word of warning: if you wish the drug to be Formulary standard, the letters "C.F." must be written after the name of the drug or preparation.

Curiosity is one of the permanent and certain characteristics of a vigorous intellect. Every advance into knowledge opens new prospects and produces new incitement to further progress.—*Johnson.*

News Items

— of —

Department of Health and Public Welfare

The Medical Health Officer and "The Hospital Aid Act"

THE problem which has presented itself to the medical profession during the past few years in the care of persons on relief, or others who are unable to pay for medical treatment or nursing care, is reflected in the situation which now prevails in connection with patients in the Public Wards in all the Public Hospitals in Manitoba.

The St. Boniface Sanatorium, Ninette Sanatorium, and the Central T.B. Clinic, being in large part under the Levy, any figures used, or references made to hospitals here, do not include these three Institutions. They account for approximately 25% of all the Public Ward Hospital days, and present a problem of their own.

The number of hospital days in the Public Wards have been gradually increasing. A sharp upturn was present in 1930, and at the present time there is a 50% increase over the figure of 10 years ago. During this same period the population has increased about 12% and the available Public Ward beds have been increased by about 20%.

In 1924 this represented about $554,000.00 which might be charged back against the Municipalities, and for the past year, estimated at the reduced rate, about $784,000.00. These figures, of course, are only the maintenance charges at the specified rate, and take no cognizance of the Provincial Statutory Grant for the care of Public Ward patients.

Although no figures are immediately available several years back, it may be of interest to note that during the past year, 20% of the Hospital days in the Public Wards were taken up with mothers and new-born infants, and that of the 14,141 births in the Province, approximately 38% were born in Hospitals.

There appears to be a definite indication that there is an increased demand for Public Ward care in hospitals; not only that, but there is an increasing demand for "free" care, meaning that a large proportion of these accounts must be met out of Public Funds.

For some years past, the "Hospital Aid Act" has been "operated upon" fairly regularly, and an outline of the main changes will indicate the attempts which have been made in an endeavour to meet, or to have a favourable influence on the present situation.

Changes in the Act

An Act Respecting Aid to Charitable Institutions, or as it is more commonly called, the "Hospital Aid Act," has, since 1928, been amended four times in order to alter the definition of the term "resident" with a view toward making the residential qualifications for the determination of hospital responsibility as fair as possible, for each Municipality.

In 1928, individuals for hospitalization purposes might be a municipal responsibility if they resided in a given municipality for one month, or had worked for and actually been employed therein by a taxpayer of the municipality immediately prior to being admitted to the hospital. Quite a number of the municipalities, because of their geographical situation within the Province, felt themselves imposed upon in being compelled to assume financial obligations for hospitalization through this Clause in the Act. This was changed so that the requirement was the last full year's residence in a municipality, or if this could not be met, then the place where the person had spent the longest period over thirty days within the 12 months immediately prior to admission to hospital. This amendment possibly got rid of one fault, but it also was open to certain obvious objections, but it is unlikely that these would have given rise to such further legislation as has been enacted had not the changes in the economic conditions of the general population begun to be felt. Patients were being admitted in larger numbers to the Public Wards and certainly more were leaving the hospital with their accounts unsettled, which meant that these were collectible by the hospital direct from public funds.

Increasing numbers of unemployed, and the continued and steadily increasing periods of unemployment appear to have influenced the demand for treatment in the Public Wards. Some municipalities have revenue ear-marked for hospital accounts, but most have not, however, in many instances, these expenditures were assuming increasingly large proportions, and being met with difficulty.

The Medical Health Officer

During all this period, the Hospital Aid Act had empowered the Medical Health Officer to examine patients in hospitals for whom his municipality was responsible, and to take such steps as were necessary to secure the patient's discharge if in his opinion there was no necessity to retain the patient for a further period in hospital. Supervision of this kind by the Health Officer, would undoubtedly, curtail periods of hospitalization in certain instances, but even if carried out to a much greater extent than had been in the past, it is doubtful that the effort would have any appreciable influence on the situation presenting itself to the Municipalities. For some time consideration was given to the suggestion that the Health Officer be given wider powers which might enable him to have some measure of control over the patients of his municipality who were seeking admission to the Public Wards. organized 1).

In 1932 a further amendment to the Act was made, altering the Residential qualifications, and also making it necessary for a patient to obtain the written authority of the Health Officer before admission to the Public Ward of the hospital may be gained. In certain instances, this requirement would involve some danger to the patient, so an alternative method of admission was provided, whereby the medical superintendent or attending physician may authorize the admission by certifying that it was unwise to delay admission to the hospital until the authority of the Health Officer was obtained.

The main object of the attempt to regulate the admission of patients to the public wards is to avoid in so far as possible, unnecessary hospitalization. It is not possible to make any definition of "unnecessary hospitalization," but numerous ailments in certain individuals or situations require hospital care, and in others do not, so that it is expected that the Health Officer, after taking into consideration the patient's needs, characteristics, and local situation, shall decide where admission to the Public Ward is necessary.

On March 31st, 1933, the last amendment to the Hospital Aid Act came into effect. Further changes were made in the Residential qualifications, and the procedure for admission again altered.

At the present time, the procedure for the admission of a patient to the Public Ward, according to the Hospital Aid Act, is as follows:—

Written authority from the Health Officer of the Municipality in which the patient resides must be placed with the hospital, or in the event of an emergency, or where delay would be prejudicial to the best interests of the patient, admission may be obtained by the certification of the medical superintendent of the hospital, or by the attending physician. If this second course is followed, the hospital sends to the Health Officer, as soon as possible, a copy of the admission notice on which is the physician's certificate, including a statement of the nature of the illness, or the reason for the admission.

There is thus available, machinery whereby the Health Officer may exercise some control or supervision over Public Ward admissions from his municipality, and after being admitted to the hospital, he is enabled to obtain their discharge if, in his opinion, hospital care is no longer necessary.

In some circumstances it is easy to believe that opinions may vary concerning the disposition of a patient, and that the Health Officer and the hospital may hold contrary views.

In the event of a disagreement, the "Hospital Aid Act" states "If the Medical Health Officer or the physician appointed by the Municipality, for the purpose, in any case be unable to agree with the hospital as to whether or not the patient is to be discharged or retained, the Minister shall decide the question, and the patient shall be retained or discharged in accordance with his decision.

Residence

The definition of residence which determines the responsibility for hospitalization and relief purposes, states that only the three years immediately prior to admission to hospital can be considered in estimating residence, and that in reckoning time it shall be a period during which the person has not been in receipt of relief from Dominion, Province, or Municipality.

During the last three years the Municipality where the person last resided for twelve months continuously, would be that person's residence.

If this year's residence cannot be established, then the Municipality where the person has lived the longest over sixty days during the twelve months immediately prior to admission to hospital shall be deemed the residence.

A married woman takes the residence of her husband, but if she has lived separate and apart from her husband for one full year, she assumes her own residence.

A minor takes the residence of the father, but if the father is dead, or the child illegitimate, then the mother's residence is taken. Ref. (Municipal Act, Sub-sec. 2, Sec. 2, 1933 – Hospital Aid Act, 1933). —C. R. D.

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Diarrhoea and Enteritis

During 1932 there were certified in Manitoba 168 deaths from this cause: 130 were of children under one year of age, and 16 in the second year. 101 deaths occurred during the months of August, September and October: of

these, 78 were of infants, and 13 of children between one and two years of age. The following table shows the classification of infant deaths according to age:

Under one week	2
1 to 4 weeks	10
1 and under 2 months	17
2 and under 3 months	22
3 and under 4 months	14
4 and under 5 months	16
5 and under 6 months	13
6 and under 7 months	14
7 and under 8 months	5
8 and under 9 months	6
9 and under 10 months	3
10 and under 11 months	5
11 and under 12 months	3

It has been found from various studies that 90% of the infants that die from this condition are bottle fed; that the majority come from homes where the virtue of cleanliness is not recognized, and that most frequently there is a history of diarrhoea among the other members of the household.

This loss of life can only be avoided by the education of the mothers to a realization of the dangers incurred in bottle feeding and in careless handling of milk and food, and of the importance of the washing of hands. The value of the public health nurse in this direction was making itself felt when financial stress deprived half the province of her services. A challenge has thus been thrown to the health officers to devise ways and means of spreading the gospel personally, or through the press or other channels.

—N. R. R.

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COMMUNICABLE DISEASES REPORTED

(Urban and Rural)

For the Months of April and May, 1933

Occurring in the Municipalities of:—

Whooping Cough: TOTAL 320—Winnipeg 236, East Kildonan 29, St. Vital 14, West Kildonan 13, North Cypress 10, Springfield 7, Brandon 3, St. Boniface 3, St. James 2, Winnipeg Beach 2 (late report for March from Victoria 1).

Mumps: TOTAL 232—Winnipeg 123, St. Vital 56, St. Boniface 23, Transcona 10, Brandon 5, North Cypress 2, St. James 2, Kildonan East 3, Tuxedo 1, Woodlands 1 (late report from St. Vital, March 6).

Chickenpox: TOTAL 236—Winnipeg 147, Virden 22, St. Vital 16, Gilbert Plains Rural 9, DeSalaberry 8, St. Boniface 8, Brandon 4, Napinka 4, Souris 3, Gilbert Plains Village 2, Transcona 2, Dauphin R. 1, Kildonan East 1, Kildonan West 1, Shell River 1, Springfield 1, St. James 1, Turtle Mountain 1, Unorganized 1 (late report for March, Swan River T. 3).

Scarlet Fever: TOTAL 117—Winnipeg 34, Ritchot 29, Fort Garry 9, Franklin 7, St. Vital 6, Emerson 4, St. Boniface 4, Kildonan North 3, Victoria Beach 3, Roland 2, Rhineland 2, Selkirk 2, Tache 2, Unorganized 2, Portage R. 1, Westbourne 1, Whitehead 1 (late reports for February, March and April: Emerson 3, Hamiota 1, Gimli R. 1).

Tuberculosis: TOTAL 84—Winnipeg 30, Unorganized 12, St. Boniface 6, Lorne 3, Cartier 2, Hanover 2, Rhineland 2, Selkirk 2, Springfield 2, St. Vital 2, Tache 2, Armstrong 1, Cypress North 1, Dauphin R. 1, Franklin 1, Gladstone 1, Gilbert Plains V. 1, Harrison 1, Morris Rural 1, Neepawa 1, Portage R. 1, Ritchot 1, Souris 1, Stanley 1, St. James 1, Swan River R. 1, Tuxedo 1, The Pas 1, Wallace 1, Woodlea 1.

Diphtheria: TOTAL 47—Winnipeg 24, Rockwood 4, Stanley 3, Binscarth 2, Bolton 2, McDonald 2, Portage R. 2, Brandon 1, Coldwell 1, Hanover 1, Morden T. 1, Portage la Prairie City 1, Tache 1, St. Rose 1, Unorganized 1.

Measles: TOTAL 33—Winnipeg 22, Kildonan West 2, Rockwood 2, St. James 2, Roland 1, Shell River 1, St. Anne 1, St. Boniface 1, Turtle Mountain 1.

Influenza: TOTAL 21—Winnipeg 1 (late reports February: Rhineland 2, Camperville 2, Virden 2, Whitewater 2, Chatfield 1, Hillsburg 1, Miniota 1, Oakland 1, Pipestone 1, Riverside 1, Rossburn R. 1, Selkirk 1, Stanley 1, The Pas 1, Unorganized 2).

Typhoid Fever: TOTAL 15—Morris R. 5, Brandon 2, Portage la Prairie C. 2, Winnipeg 2, Bolton 1, Rhineland 1, Ritchot 1 (late report March: Rosedale 1).

Erysipelas: TOTAL 11—Winnipeg 6, St. James 2, Kildonan Old 1, Rosedale 1, Portage R. 1.

Puerperal Fever: TOTAL 2—Kildonan West 1, Rossburn 1.

Anterior Poliomyelitis: TOTAL 1—Boulton 1.

Cerebrospinal Meningitis: TOTAL 1—Portage R. 1.

Lethargic Encephalitis: TOTAL 1—Gilbert Plains V. 1.

German Measles: TOTAL 1—Brandon 1.

* * * *

DEATHS FROM ALL CAUSES IN MANITOBA

For Month of March, 1933

URBAN—Cancer 44, Pneumonia (all forms) 14, Tuberculosis 11, Congenital 10, Influenza 4, Puerperal 2, Cerebrospinal Meningitis 1, Typhoid Fever 1, all other causes 114, Stillbirths 14. TOTAL 215.

RURAL—Congenital 33, Cancer 28, Influenza 25, Pneumonia (all forms) 28, Tuberculosis 23, Puerperal 7, Cerebrospinal Meningitis 1, Diphtheria 1, Measles 1, Scarlet Fever 1, Typhoid Fever 1, all other causes 135, Stillbirths 17. TOTAL 303.

INDIANS—Influenza 10, Tuberculosis 8, Congenital 7, Pneumonia 3, Puerperal 2, all other causes 5, Stillbirths 2. TOTAL 37.

GRAND TOTAL - - - 555

INJURIES TO TISSUES

LONG-CONTINUED suppurations, resulting from wounds and other injuries to the tissues, may be speedily overcome by general irradiation, in addition to local treatment.

Antiphlogistine, due to its ability to prolong hyperaemia, to its plasticity, which enables it to cling to any part of the body, and to its antiseptic and osmotic qualities, which help to overcome infection, raises the resistance of the patient, so that striking results in rapid healing are often obtained by this mode of treatment.

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THE DENVER CHEMICAL MANUFACTURING CO.
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Re-Organization of Nursing Services by Manitoba Association of Registered Nurses

A WRITER recently stated that from the beginning of the economic depression up to the present time more books have been read than ever before in the same length of time. People without employment turn to books as a pastime and why not? Could there be a more opportune time to improve education? Leisure time if used properly can be a decided asset, to encourage the pursuit of legitimate hobbies, to foster one's creative talent. If one belongs to an organization of any kind and the majority of members are found to have leisure time, is not that a splendid opportunity to re-organize, to study and be prepared to be one of the first organizations to advance when times pick up? In aiding those of the organization who badly need employment why not let the work given be of educational value when possible?

The Manitoba Association of Registered Nurses is endeavoring to keep these facts in mind when aiding its unemployed. At the beginning of the year the Association voted a sum of money towards aiding its unemployed nurses. This money is being used to foster a scheme known as the "Interchange of Nurses Scheme." An unemployed registered nurse is given three months' post-graduate work in a hospital other than the one in which she trained and given a small monthly salary as well as her board, room and laundry. She is not earning a great deal but she is kept busy and is learning. Will she not be in a better position to carry on when things pick up?

As for re-organization in leisure time, in organizing in any time, the Manitoba Association of Registered Nurses or any nursing organization for that matter realize that to serve the public is their biggest aim, to provide the best of nursing services at the most convenient cost.

Recently a reduction was made in hourly nursing services to enable a patient to employ a nurse in the home for from one to three hours at a time if their condition does not necessitate constant care. More recently an eight-hour nursing day has been offered the public at a reduced fee of three dollars a day. Many patients require a nurse only during the hours that other members of the family are at business. An eight-hour day, however, applies to hospital cases as well as patients in the home. Many people who have been employing two nurses on twelve-hour duty at five dollars a day or night as the case may be, can now aid unemployment by employing three nurses instead of two and at the same time save themselves a dollar a day. Not only is this an advantage to the patient, but it gives the nurse a shorter working day, something nurses have been striving for for years.

Re-organization and preparations for better times are going on all around us, higher standards are being set up, higher entrance qualifications are being asked for at entrance to schools of nursing, standard curricula will shortly be used throughout the province and it is the aim of nursing organizations to bring about a standard Registered Nurses' examination in the Dominion so that no matter where a nurse is employed the patient may be assured that he or she is employing someone who can and will give nothing but the highest quality of nursing services obtainable.

—Submitted by Manitoba Association of Registered Nurses.

History of Medicine in Canada

By W. A. Gardner

First Physicians in Upper Canada

THE first English speaking physicians in Upper Canada were retired Army Officers. There was no license to practice till an act was passed in 1815. In 1819 John Gilchrist was licensed to practice Physic Midwifery and Surgery and was arrested later as a sympathizer with the MacKenzie rebellion.

Christopher Widmer was called the father of surgery in Upper Canada and was considered the most skilful surgeon on the continent. For ten years from 1815 he was the only qualified doctor in York. He was the leader in the General Hospital, a Fellow of the Royal College of Surgeons, and a military staff surgeon. He was medical referee to the United Empire Life Association, a director of the Bank of Upper Canada, Trustee of the General Hospital of Upper Canada, a member of the University of King's College, a member of the Legislative Council of Upper Canada. He led apparently an extremely busy life.

Dr. Grant Powell was born in Norwich, England, in 1779. His father became Chief Justice of Upper Canada. After studying medicine at Guy's he came to the States, then to Montreal and finally to York during the War of 1812 and 1813, when he was surgeon to the incorporated Militia. In 1820 he was made Judge of the Home District Court. Many of the doctors were also lawyers and practiced both professions as well as doing a bit of preaching in some instances.

Dr. John Rolph was born in Gloucester, England, and came to Canada in 1812. He became a politician, member of the bar and a lecturer in Medicine. He was an outstanding lecturer, a pupil of Sir Astley Cooper's, and is believed to have also studied divinity and applied for Holy Orders. In the rebellion of 1837 he sided with MacKenzie, and after its failure fled to the States. He returned in 1843 and started "Rolph's School of Medicine," which later became "The Toronto School of Medicine" under Dr. Workman, Dr. Park and Dr. Rolph.

Dr. William Dunlop, who practiced in York, took part in the war of 1812-13-14 against the Americans. He went to India with his regiment, returned to Edinburgh where he lectured on Medical Jurisprudence and wrote a book on the war of 1812. His peculiar will, which he wrote himself and which was duly executed, is reproduced here in full:—

"In the name of God, Amen. I, William Dunlop, of Fairbraid in the Township of Colborne, County and District of Huron, Western Canada, Esquire, being in sound health of body, and my mind just as usual, which my friends who flatter me say is no great shakes at the best of times, do make this my last will and testament as follows — revoking, of course, all former wills.

"I leave the property of Fairbraid and all other landed property I may die possessed of, to my sisters Ellen Boyle Story, and Elizabeth Boyle Dunlop, the former because she is married to a minister whom (God help him!) she henpecks: the latter, because she is an old maid and not market-rife; and also I leave to them and their heirs my share of the stock of implements on the farm, provided always that the enclosure round my brother's grave be reserved, and if either should die without issue then the other to inherit the whole.

"I leave my sister-in-law, Louisa Dunlop, all my share of the household furniture and such traps with the exceptions hereinafter mentioned.

"I leave my silver tankard to the oldest son of old John, as the representative of the family; I would have left it to old John himself, but he would melt it down to make temperance medals, and that would be a sacrilege —however, I leave my big horn snuff-box to him, he can only make temperance horn spoons of that.

"I leave my sister Jenny my Bible, the property formerly of my great-great-grandmother, Bethia Hamilton, of Woodhall, and when she knows as much of the spirit of as she does of the letter, she will be another guise—Christian than she is.

"I also leave my late brother's watch to my brother Sandy, exhorting him at the same time to give up wiggery, radicalism, and all other sins that do most easily beset him.

"I leave my brother Alan my big silver snuff-box, as I am informed he is rather a decent Christian, with a swag belly and a jolly face.

"I leave parson Chevasse (Maggie's husband) the snuff-box I got from the Sarnia Militis, as a small token of my gratitude for the service he has done the family in taking a sister that no man of taste would have taken.

"I leave John Caddle a silver tea-pot, to the end that he may drink tea therefrom to comfort him under the affliction of a slatternly wife.

"I leave my books to my brother Andrew, because he has been so long a jungley-wallah, that he may learn to read with them.

"I give my silver cup with a sovereign in it to my sister, Janet Graham Dunlop, because she is an old maid and pious, and therefore will necessarily take to horning, and also my gran'ma's snuff-mull, as it looks decent to see an old woman taking snuff.

"I do hereby constitute and appoint John Dunlop, Esquire, of Fairbraid; Alexander Dunlop, Esquire, Advocate, Edinburgh; Alan C. Dunlop, Esquire, and William Chalk, Esquire, Goderich, to be the executors of this my last will and testament.

"In witness whereof I have set my hand and seal the thirty-first day of August, in the year of our Lord one thousand eight hundred and forty-two."

The Indians had a very considerable knowledge of the medicinal properties of herbs, barks, and roots. The women looked after the sick and the obstetrics. "As soon as a woman believed herself pregnant she must acquaint her husband. When she is near being delivered she leaves the hut and goes away into the wood with another woman to assist her and the business is soon over. The woman delivered gives her assistant the knife which cut the navel string, and that is all her reward. The new born is immediately washed in winter as in summer. Its first nourishment is the oil of fish or melted tallow which it is made to swallow and thereafter has nothing but the mother's milk."

The method of treating the drowned was to fill the paunch or a long gut with tobacco smoke tying up one end of it and fixing a tobacco pipe into the other end. The pipe stem was introduced into the bowel and the smoke squeezed out of the gut into the patient. He was then hung up by the heels to the nearest tree "where the clyster of smoke makes them cast up all the water they have swallowed and brings them to life again."

The diseases of the Indians were due to exposure, hunger and injury. Diseases of the eyes often leading to blindness were due to the smoky wigwams with only a hole in the roof. Scurvy was very common. Wounds were washed and covered with cold water from springs and streams and when septic dressed with slippery elm bark, basswood, and tamarack. They had bone setters who reduced dislocations by main force. For fractures they used splints of cedar or broom padded by the squaws with leaves and grass and tied with young birch branches. The broken limb was often dressed with moss and turpentine splinted with birch bark that soon took the shape of the limb. Amputations were done at the joints with sharp flint. Vessels were seared with heated stones.

Nursing began with the religious orders in Europe and it is written of the sisters of the Hotel Dien at Quebec: "They endured with cheerfulness and without repugnance the stench, the filth and infections of the sick, so insupportable to others, that no other form of penitence could be compared to this form of martyrdom. No one who saw the sisters not only do dressings, make beds, and bathe the patients, but also in cold weather break the ice in the river and stand knee deep in the water to wash the filthy clothes, could regard them as other than holy victims, who from excess of love and charity for their neighbors hastened willingly to the death which they courted amongst the stenches and infections."

Medical Library of the University of Manitoba

A summary of the contents of some of the journals available for practitioners, submitted by the Faculty of Medicine of the University of Manitoba. Compiled by T. E. Holland, B.Sc., M.D. (Man.), F.R.C.S. (Edin.).

BRITISH JOURNAL OF SURGERY, April, 1933.

"The Treatment of Acute Empyema in Infancy and Childhood,"
by J. D. McEachern, M.D., Chief Surgeon, Children's Hospital, Winnipeg.
—Dr. McEachern describes in detail the method of treatment by closed drainage, and reports 75 consecutive cases so treated.

"Acute Infective Osteomyelitis: A Review of 262 Cases,"
by L. N. Pyrah, M.D., and A. B. Pain, M.D., Surgical Registrars, General Infirmary, Leeds.
—A full discussion of the subject and the various methods of treatment. They believe their results point to the advisability of moderately conservative treatment for acure osteomyelitis.

THE CLINICAL JOURNAL, May, 1933.

"The Natural History, Prognosis and Treatment of Infections with Bacillus Coli Communis,"
by John A. Ryle, M.D., F.R.C.P., Physician to Guy's Hospital, London.
—A discussion of the results of excretion of bacillus coli via the urinary and biliary tracts during a transient bacillaemia, and the treatment of these conditions.

"The Acute Abdomen in Children,"
by L. E. Barrington-Ward, F.R.C.S., Senior Surgeon, Royal Northern Hospital; Surgeon, Hospital for Sick Children, Great Ormond Street, London.
—A complete discussion of diagnosis and treatment.

"Diagnosis and Treatment of Ante-Partum Hæmorrhage,"
by C. H. G. Macafee, M.B., F.R.C.S., F.C.O.G., Gynæcologist, Ulster Hospital for Women; Assistant Obstetrical Surgeon, Belfast Maternity Hospital.

LANCET, April 15th, 1933.

"Physiology of the Gall-bladder and Its Functional Abnormalities,"
by Charles Newman, M.D., F.R.C.P.
—The first of the "Goulstonian Lectures" delivered before the Royal College of Physicians of London. Lectures II. and III. are in the "Lancet" of April 22nd, 1933, and April 29th, 1933.

LANCET, May 13th, 1933.

"Epilepsy and Conditions with Similar Symptoms: With Observations on Hypnotic, Epileptic, Traumatic and Hysterical Dissociation,"
by Hildred Carrill, M.D., Physician to Westminster Hospital.
—An excellent article illustrated by numerous case reports.

"Diverticula of the Thoracic Oesophagus,"
by N. R. Barrett, M.Ch., F.R.C.S. (Eng.), Chief Assistant, Surgical Unit, St. Thomas's Hospital.

"Report of a Case Treated by Mr. W. H. C. Romanis."

"Diverticula of the Pharyna and Oesophagus: Correlation of Pathological and Radiological Appearance,"
by R. W. Raven, F.R.C.S. (Eng.), St. Bartholomew's Hospital, London.
—Well illustrated by X-ray plates.

THE CANADIAN MEDICAL ASSOCIATION JOURNAL, May, 1933.

"The Diagnosis and Treatment of Carcinoma of the Colon and Rectum,"
by D. F. Jones, M.D., Boston.
—A comprehensive paper on this subject, read at the Annual Meeting of the Canadian Medical Association, Toronto, June, 1932.

"Parathyroid Dysfunction: Report of a Case Treated with Parathormone and Irradiated Ergosterol,"
by S. Ortenberg, M.D., Montreal.
—A discussion of the effect of parathyroid activity on bone metabolism in normal and hyper-active states. The case recorded was apparently a clear-cut case of osteitis fibrosa cystica. The patient, refusing exploratory operation for parathyroid adenoma, was treated with parathormone for delayed union of a fracture (traumatic), with resultant increase in density in all bones affected by the osteo-dystrophy and also complete union of the fractures. Dr. Ortenberg's conclusion is that the osteo-dystrophies may be due to an hypo-parathyroidism or hyper-parathyroidism, and require treatment by either parathormone or parathyroidectomy, according to the condition, which must be determined by chemical studies.

"Disturbances Produced in the Rectum by Disease Elsewhere,"
by E. A. Daniels, M.Sc., M.D., Montreal.

"The Toxæmias of Pregnancy,"
by Wm. J. Stevens, M.D., C.M., F.R.C.S., Ottawa.

"Functional Dyspepsias,"
by John W. Scott, M.D., F.R.C.P. (C.), Edmonton.

Clinical Meetings

At Brandon General Hospital—
2nd Wednesday at 12.30 p.m.

At Brandon Hospital for Mental Diseases—
Last Thursday. Supper at 6.30 p.m.
Clinical Session at 7.30 p.m.

At Children's Hospital—
1st Wednesday.
Luncheon at 12.30 noon.
Ward Rounds 11.30 a.m. each Thursday.

At Grace Hospital—
3rd Tuesday.
Luncheon at 12.30 p.m.
Discussion of Obstetrical Cases will form a large part of the clinical hour.

At Misericordia Hospital—
2nd Tuesday at 12.30 p.m.

At St. Boniface Hospital—
2nd and 4th Thursdays.
Luncheon at 12.30. Meeting at 1.00 p.m.
Ward Rounds 11.00 a.m. each Tuesday.

At St. Joseph's Hospital—
4th Tuesday.
Luncheon at 12.30. Clinical Session 1.00 to 2.00 p.m.

At Victoria Hospital—
4th Friday.
Luncheon at 12.00. Meeting at 1.00 p.m.

At Winnipeg General Hospital—
1st and 3rd Thursdays.
Luncheon at 12.30. Clinical Session 1.00 to 2.00 p.m.
Ward Rounds 10.00 a.m. each Thursday.
Pathological Conference at Medical College at 9.00 a.m. Saturday during college term.

Winnipeg Medical Society—
3rd Friday, Medical College, at 8.15 p.m.
Session: September to May.

Eye, Ear, Nose and Throat Section—
1st Monday at 8.15 p.m., at 101 Medical Arts Building.